LeMed
SPECIALTY PHARMACY

XIFAXAN 550

2417 3rd Ave, Ste 406
Bronx, NY 10451
Phone: 347-913-4656
Fax: 718-231-2727

Patient Information - Please send demographic sheet and a copy of the patient's insurance cards				
Patient Name:	Date of Birth:	☐ Male ☐ Female		
Address:	City:	State:	Zip:	
Mobile Phone:	Home Phone:	Language:		
Allergies **(Required):** ☐ NKDA	Height:	Weight:	SSN:	
Medication Delivery Options: ☐ Patient's Home ☐ Hospital/Clinic Office ☐ Bedside **Delivery Address:**				

Prescriber Information			
Practice Name:	Office Contact:		
Prescriber:	NPI:	DEA:	
Practice Address:	City:	State:	Zip:
Phone Number:	Fax Number:		

Clinical Information - Please send all available chart notes including lab results
ICD-10:
Therapies tried and failed with length of treatments:

Medication Name	Strength	Dose/Frequency
☐ Xifaxan	550 mg	Take 1 tablet by mouth twice daily
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The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing below, I hereby authorize LeMed Specialty Pharmacy and/or its affiliate pharmacies to facilitate benefits investigations, complete and submit prior authorization (PA) requests, appeals, step edits and other processes necessary to obtain coverage for prescribed medications, to sign any necessary forms on my behalf of my patients, and to attach its Enrollment Form to the PA request as my signature.

IMPORTANT NOTICE: This form is intended to be delivered only to the named addressee. It contains material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.

***Fax does not constitute a valid prescription as per NYS Board of Pharmacy. Please electronically prescribe order.**

Prescriber Signature: _____ **Date:** _____